STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEGATE COMMONS ASSISTED LIVING	7525 ROSEGATE DRIVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	R000000 This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00144899. Complaint IN00144899 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 24, 25, 26, & 27, 2014. Facility number: 012936 Provider number: 012936 AIM number: N/A Survey team: Marcy Smith, RN-TC Patti Allen, SW (February 24, 25, & 27, 2014) Dottie Plummer, RN (February 25, 26, & 27, 2014) Census bed type: Residential: 85 Total: 85 Census Payor type: Other: 85 Total: 85 Residential sample: 9	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These state residential findings are cited in accordance with 410 IAC 16.2. Quality review completed on March 05, 2014; by Kimberly Perigo, RN.			
R000297	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to obtain insulin as ordered by the physician for 1 of 2 residents reviewed for diabetes in a sample of 9. (Resident #66) Findings include: The clinical record of Resident #66 was reviewed on 2/25/2014 at 4:15 p.m. Diagnoses included, but were not limited to, diabetes, hypertension, neuropathy, depression, and dementia.	R000297	It is the common practice of this facility to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. **CORRECTIVE ACTIONS:** **Resident number #66** - physician notified that resident was discharged from hospital with sliding scale orders that were not transcribed to medication administration record by nurse. Physician was also made aware that resident was to receive insulin Lispro by sliding scale and	03/14/2014

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	Resident #66 was re-admitted to the facility on 1/21/2014, following a hospital admission for altered mental status, seizure, and dementia. The "After Visit Summary" indicated Resident #66 was to start insulin lispro, (Humalog), based on a sliding scale. The sliding scale indicated Resident #66 was to receive 1 unit of insulin lispro for a blood sugar of 150-199, 2 units of insulin lispro for a blood sugar of 200-249, 3 units of insulin lispro for a blood sugar of 250-300, 4 units of insulin lispro for a blood sugar of 301-349, 5 units of insulin lispro for a blood sugar of 350-400, and 6 units for a blood sugar greater than 400, and the physician was to be called. During a review of the "Capillary Blood Glucose Monitoring Tool" for Resident #66, a result of 163 mg/dl (milligram/deciliter) was documented for 2/24/2014 at 7:00 a.m. Based on this documented result, Resident #66 should have received 1 unit of insulin lispro, as indicated by the physician's order for sliding scale insulin. A zero was documented in the column, "Units of SQ (subcutaneous) Insulin [zero units administered]," for 2/24/2014. A review, on 2/24/14, of the		had not been given. At this time, physician gave new order to discontinue all current sliding scale orders and to discontinue all insulin orders (Humalog). New order obtained from physician for resident #66. Metformin 1000 milligrams - one by mouth two times per day - and finger sticks for blood sugar twice per day before meals. **IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL AND CORRECTIVE ACTION TO BE TAKEN:** All residents on sliding scale have the potential to be affected. Clinical director provided in-service on 3/10/14 to all licensed nursing staff and focused on residents returning with new medication orders. Clinical Records have been audited by clinical director of residents receiving insulin. **MEASURES PUT INTO PLACE:** **1)** All new admitting orders will be reviewed by clinical director throughout the week (Monday through Friday) once admission is completed by admitting nurse. If readmit or new admission occurs on weekends, admission orders will be reviewed by second nurse working during shift of admission. Clinical director will review the following Monday to ensure accuracy. **2)** It will be evident the clinical director reviewed the	

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	February 2014 medication administration record (MAR) for Resident #66 indicated Resident #66 was to receive insulin lispro daily at 9:00 a.m., by sliding scale dosage. Initials were documented for 2/24/2014, at 9:00 a.m., and were circled. Documentation on the MAR indicated, "2/24/14, 9 AM Humalog ordered from Pharmakon." The MAR did not contain any initials for Humalog on any other day in the month of February(February 21 - 23, 2014). During an interview with the Clinical Director on 2/25/2014 at 10:45 a.m., the Clinical Director indicated, "The staff should thoroughly review orders when the resident goes out and should clarify any orders that have changed. Any new medications should then be ordered from the pharmacy." The Clinical Director indicated the staff should have ordered the insulin lispro when Resident #66 returned from the hospital on 1-21-2014, and the pharmacy should have delivered the medications with the next scheduled delivery. The Clinical Director indicated Resident #66 should have received 1 unit of insulin lispro on 2/24/2014 at 9:00 a.m., as indicated by the blood glucose result of 163		admission orders as the clinical director's signature will be located at bottom of the medication administration record. **3)** All insulin orders will be reviewed and co-signed by two licensed nurses. No insulin orders can be transcribed without two licensed nurses. **4)** Both nurses reviewing orders will sign to indicate insulin orders were reviewed by two licensed personnel. **5)** Any insulin written on medication administration record will be checked by two licensed nurses and initials to indicate reviewed. **6)** No insulin orders will be discontinued without validation/signature of two licensed nurses. **7)** Any new medications from admission/readmits when using Pharmakon, will be sent stat to facility. Admitting nurse to document on 24 hour report and inform oncoming nurse of new medication status. **8)** If medications are not received by time the admitting licensed nurse leaves shift, oncoming nurse will call Pharmakon to obtain status of arrival of medications. If medication not received in an 8 hour period, staff to notify clinical director, family and physician. **CORRECTIVE ACTIONS:** Clinical director will review all admits/readmits within 24 hours of admission if occurs (Monday through Friday). Clinical director will review all	

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	mg/dl. The Clinical Director indicated the initials within a circle indicated the medication was not administered. During an interview with LPN #1 on 2/27/2014 at 10:15 a.m., LPN #1 indicated the insulin lispro for Resident #66 was stored in the refrigerator. LPN #1 retrieved a pharmacy bottle from the refrigerator. The bottle contained an unopened vial of insulin lispro. The label on the unopened vial of insulin lispro indicated the vial was filled on 2/24/2014, for Resident #66.		admits/readmits within 48-72 hours if admission occurs on weekend. Clinical director will review clinical charts for at least 6 months to ensure physician orders are being followed. **WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Effective no later than 03/14/14.	

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R000298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, record review, and interview, the facility failed to ensure controlled substances were counted and verified, according to the facility policy, for 2 of 2 observations of controlled substance counting and verification. (LPN #1 and LPN #2) Findings include: 1. During an observation on 2/24/14 at 2:05 p.m., LPN (Licensed Practical Nurse) #1 was standing in front of medication cart 2. He appeared to be counting controlled substances/medications by himself. He indicated, at that time, he was doing a shift change narcotic count. He indicated the nurse who was	R000298	It is the common practice of this facility to ensure that controlled substances were counted and verified according to applicable laws of Indiana and facility's policy. **CORRECTIVE ACTIONS:** Narcotic counts are being completed on each unit per policy. **IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL AND CORRECTIVE ACTION TO BE TAKEN:** All residents that are receiving narcotics have the potential of being affected. Clinical Director provided educational inservice to all licensed nurses on 3/10/14. **MEASURES:**	03/14/2014

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	going off shift would co-sign the count, verifying the count was accurate. LPN #3 came out of the nurses' office at 2:08 p.m., and indicated she was the nurse who had been on medication cart #2 during the day shift and would be the nurse who would verify LPN #1's controlled substance count for this cart. She indicated, at that time, she she didn't know LPN #1 had started the controlled substance count. She indicated, "He should have told me." 2. During observation on 2/24/14 at 2:05 p.m., LPN #2 was standing in front of medication cart 1. She appeared to be counting controlled substances/medications by herself. During an interview with LPN #2 on 2/25/14 at 4:10 p.m., she indicated no one else was counting with her on 2/24/14 at 2:05 p.m.. She indicated 2 nurses were always supposed to count the controlled substances at shift change. During an interview with the Clinical Director on 2/24/14 at 3:50 p.m., she indicated there should always be 2 nurses counting the controlled substances at each shift change. A facility policy, dated 1/10, received from the Clinical Director on 2/24/14		**1)** A copy of the narcotic count policy/procedure was reviewed with licensed nursing staff on 02/24/14 by clinical director. All nursing staff verbalized their understanding of the policy/procedure and clearly understand they must count all narcotics with two licensed nurses present at all times. **2)** Licensed nursing staff must not leave the medication cart when count is taking place. **3)** After all narcotics are counted and determined to be correct, both nurses will sign and date narcotic count sheet. **4)** Clinical director will perform audits for 6 months. **CORRECTIVE ACTIONS:** Immediately notified staff on duty and provided a copy and reviewed the policy/procedure for narcotic counts. The clinical director met with all licensed nursing staff. Clinical director will perform audits for 6 months for narcotic count to ensure policy/procedure is being followed. After performing weekly random audits, clinical director will provide signature at bottom of narcotic count sheet. **WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** All staff educated and practices put into place effective 03/14/14.	

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	at 2:40 p.m., titled,"Controlled Substances," indicated, "...3. In addition to the Medication Sheet and the Schedule II Narcotic sheet, the number of controlled substances on hand must be counted and verified at the end of each shift. The Narcotic Sign In Sheet must be completed at the end of each shift every day. The outgoing Nurse or her designee will count all controlled substances being stored at the community/facility while the oncoming nurse or his or her designee watches. Both staff members sign that the count and verification have been completed." 410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.			
R000306				

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	Based on record review and interview, the facility failed to ensure disposition of medications was done according to facility policy for 2 of 2 residents reviewed for disposition of medications. (Resident #89 and #88) Findings include: 1. The closed clinical record of Resident #89 was reviewed on 2/26/14 at 9:20 a.m. Diagnoses included, but were not limited to, high blood pressure, hypothyroidism, and gastroesophageal reflux disease. Resident #89 passed away on 11/5/13. Physician ordered medications for Resident #89, current at the time of her death included, but were not limited to, Omeprazole 20 mg (milligrams) for gastroesophageal disease, Synthroid 50 micrograms for hypothyroidism, and metoprolol 25 mg for high blood pressure. There was no documentation in Resident #89's record, which indicated the disposition of these medications after her death.	R000306	It is the common practice of this facility to ensure disposition of medications was done according to facility policy. **CORRECTIVE ACTION #88 - #89:** Resident #88 and #89 no longer reside in facility. **IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL AND CORRECTIVE ACTION TO BE TAKEN:** All residents discharging from the facility have the potential to be affected. Clinical Director in-service licensed nursing staff on 3/11/14. Clinical director to implement checklists, for licensed nurses, to follow upon discharge of resident. Checklist will include instructions related to releasing medications to family and returning medications to pharmacy or destruction of medication. **MEASURES:** **1)** Nurses in-serviced on policy/procedure on disposition of medication and copy of policy provided to each licensed nurse. **2)** Nurses verbalized the understanding of disposition of medication policy. **3)** Educational binder had been placed in nursing station and is available as a resource to nurses. Included in this educational binder is the disposition policy/procedure and a	03/14/2014

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	2. The closed clinical record of Resident #88 was reviewed on 2/26/14 at 8:45 a.m. Diagnoses for Resident #88 included, but were not limited to, high blood pressure, coronary artery disease, dementia, arthritis, and tremors. Resident #88 was discharged to another facility on 11/30/13. Physician ordered medications for Resident #88, current at the time of his discharge included, but were not limited to, Tylenol 325 mg. (milligrams), Cardura 2 mg., Prilosec 20 mg., Plavix 75 mg., Zocor 20 mg., Exelon patch 9.5 mg., aspirin 81 mg., Sinemet 25-100 mg., and hydralazine 25 mg. A nurse's note, dated 11/30/13 at 3:00 p.m., indicated Resident #88's daughter had, "picked up all medications." The record did not indicate which or how many, medications were given to the daughter. A physician's order was not found in the resident's record, which indicated the resident's medications could be released to his daughter. During an interview with the Clinical Director, on 2/26/14 at 11:10 a.m.,		discharge checklist. **CORRECTIVE ACTIONS/MONITORING:** **1)** After discharge of a resident the clinical director will review clinical chart within 48-72 hours for at least 6 months to ensure disposition of medications were done properly. **2)** Discharge checklist copy to be given to clinical director from nursing staff for review. Prior to the release of medications the nurses will obtain a physician's order to include a list of all medications released and quantity provided will be documented on the medication release form. The order, along with the medication release form will become a part of the clinical record. **COMPLETION DATE:** All staff educated and practices put into place immediately effective 03/14/14.	

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	she indicated there was no record of the dispensation of medications for Residents #89 and #88 after they left the facility, except for the note in Resident #88's record, which indicated the resident's daughter had picked up the medications. A facility policy, dated 7/2011, received from the Administrator on 2/27/14 at 10:55 a.m., titled, "Disposition of Medications when a Resident is Discharged from the Facility," indicated, "...A medication may be released...upon discharge only with a physician's order specifying which medications are to be released...The nurse will document in the clinical record and/or the 'Medication Release form.' "			
R000352	410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. Based on interview and record	R000352	It is the common practice of this	03/14/2014

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	review, the facility failed to document the results of blood glucose monitoring ordered by the physician, for 1 of 2 residents reviewed for diabetes in a sample of 9. (Resident #66) Findings include: The clinical record of Resident #66 was reviewed on 2/25/2014 at 4:15 p.m. Diagnoses included, but were not limited to, diabetes, hypertension, neuropathy, depression, and dementia. Resident #66 was re-admitted to the facility on 1/21/2014, following a hospital admission for altered mental status, seizure, and dementia. The "After Visit Summary" indicated Resident #66 was to start insulin lispro, (Humalog), based on a sliding scale. Resident #66 was seen in the emergency room on 2/6/2014. The "After Visit Summary" indicated Resident #66 had diagnoses including, but not limited to, "ALTERED AWARENESS, TRANSIENT, and UTI (Lower Urinary Tract Infection)." The "After Visit Summary" indicated Resident #66 was to "...Continue These		facility to document and record blood glucose in the clinical record. **CORRECTIVE ACTION:** **Resident number #66** - physician notified that resident was discharged from hospital with glucose monitoring scheduled three times daily and order had not been transcribed or performed by the licensed nurse. At this time, physician gave new order to discontinue all previous blood sugar orders. New order obtained from physician for resident #66 indicating finger sticks for blood sugar twice per day before meals (breakfast and dinner). **IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL AND CORRECTIVE ACTION TO BE TAKEN:** All residents on insulin have the potential to be affected. Clinical director provided in-service on 3/10/14 to all licensed nursing staff and focused on residents returning with new medication orders and insulin. Clinical Records have been audited by clinical director of residents receiving insulin. **MEASURES PUT INTO PLACE:** 1) All new admitting orders will be reviewed by clinical director throughout the week (Monday through Friday) for at least 6 months, once admission is	

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	Medications Which Have Not Changed...insulin lispro (Humalog) 100 unit/ml [milliliter], inject into skin 3 (Three) times daily as needed Per sliding scale..." The physician's order on 2/6/2014 indicated Resident #66 was to have glucose monitoring 3 times a day. A review of the "Capillary Blood Glucose Monitoring Tool" for Resident #66 for the month of February 2014, indicated Resident #66 should have "Accucheck qd [every day], and prn [as needed]." The documentation indicated the blood glucose was checked once daily at 7:00 a.m., 2/1/2014 through 2/26/2014. During an interview with the Clinical Director on 2/25/2014 at 10:45 a.m., the Clinical Director indicated, "The staff should thoroughly review orders when the resident goes out and should clarify any orders that have changed. Any new medications should then be ordered from the pharmacy." The Clinical Director indicated Resident #66 should have received blood glucose monitoring 3 times a day, as indicated by the physician's order 2/6/2014.		completed by admitting nurse. If readmit or new admission occurs on weekend, new admissions ordered will be reviewed by second licensed nurse working during shift of admission. Clinical director will review the following 48-72 hours to ensure accuracy. 2) Admitting nurse will create corresponding accu-check log that will consist of the time accu-check was completed, value obtained and licensed nurse's signature. 3) All documentation to be maintained within the clinical record. 4) It will be evident the clinical director reviewed the admission orders as evidence by second signature at bottom of the medication administration record. **CORRECTIVE ACTIONS:** Clinical director will review all admits/readmits within 24 hours of admission if occurs (Monday through Friday). Clinical director will review all admits/readmits within 48-72 hours if admission occurs on weekend. Clinical director will review clinical charts for at least 6 months to ensure physician orders are being followed. **WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Effective no later than 03/14/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEGATE COMMONS ASSISTED LIVING	7525 ROSEGATE DRIVE INDIANAPOLIS, IN 46237

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